Save the Children

Maternal and Child Survival Through Local Women Health Workers:
Testing Innovative Strategies for the Hills of Nepal

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September 30, 1999 to September 29, 2003

Nepal CS-15
Third Annual Report

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Annexes

Abbreviations

ARI	: Acute Respiratory Infection
ANM	: Auxiliary Nurse Midwife
AHW	: Auxiliary Health Worker
BCC	: Behavioral change and communication
BEOC	: Basic emergency obstetric care
CDD	: Control of Diarrhoeal Disease
CB-IMCI	: Community Based Integrated Magement of Childhood Illness
CS-XV	: Child Survival XV
CHW	: Community Health worker
DHO	: District Health Office, District Health Officer
DD	: Diarrhea Disease
DTOT	: District Training of Trainer
DPM	: District Program Manager
FCHV	: Female Health Volunteer
F/P	: Family Planning
HF	: Health Facility
HC	: Health Coordinator
HP	: Health Post
HA	: Health Assistant
IC	: Ilaka Coordinator
JJ	: Jeevan jal (Oral Rehydration Solution)
JSI	: John Snow International
MDO	: Monitoring and Documentation Officer
MCHW	: Maternal and Child Health Worker
MNC	: Maternal and New Born Care
MoH	: Ministry of Health
MTOT	: Master Training of Trainer
NRCS	: Nepal Red Cross Society
OPD	: Out Patient Department
ORS	: Oral Rehydration Solution
ORT	: Oral Rehydration Therapy
PCM	: Pneumonia Case Management
PHCC	: Primary Health Care Center
PHCCI	: Primary Health Care Center inchrge
PNC	: Post Natal Care
PHO	: Public health Officer
R/R	: Respiratory Rate
RHO	: Reproductive Health Officer
SC/US	: Save the Children USA
S/HA	: Senior HA
SN	: Staff Nurses
SHP	: Sub Health Post
SHPI	: Sub Health Post incharge
TOT	: Training of Trainer
TTBA	: Trained Traditional Birth Attendants
TH	: Traditional Healer
VDC	: Village Development Committee
VHW	: Village Health Worker
WHO	: World Health Organization

1. Background

Save the Children US (SC/US) has been implementing the Child Survival XV Project (CS XV) in partnership with the Nepal Red Cross Society (NRCS) and the District Health Office (DHO) Nuwakot since October 1999. This project covers the entire district, which is administratively divided into 61 Village Development Committees (VDCs) and one municipality. The project period is four-years from October 1999 to September 2003. The project has planned to be implemented in two phases. The first phase, early intervention area covers 32 VDCs and the phase two late intervention area covers the rest of the VDCs. Total potential beneficiaries population in the project area is 100,500, of which 445,00 are under 5 children and 560,00 are married women of reproductive age. The total population of Nuwakot district is 287,643 (2001 Census).

The majority of ethnic group in the district is "Tamang". The Tamang are one of most disadvantaged ethnic groups in the Nepal for whom health outcomes, including infant mortality, have been found worst. Women and children receive very limited health care services due to lack of availability of qualitaty maternal and child health services. The main causes of under five children deaths are pneumonia and diarrhea. Very poor access to obstetric services for most of women in Nuwakot likely contributes to high maternal mortality.

The Project is implemented in partnership with the Nepal Red Cross Society (NRCS) district chapter and District Health Office of Nuwakot (DHO), of the MOH. NRCS staff placed in sub-health posts provide support to the existing MOH health facility health workers to improve their competency in selected services. The project has been enhancing the capacity of health workers in the existing MOH structure, especially female community health volunteers (FCHVs) and Maternal and Child Health Workers (MCHWs).

Goal:

The overall goal of the project is sustained reduction of under-five and maternal mortality among the most disadvantaged communities in the district through maternal and child health related interventions.

Program Strategies:

The following strategies have been adopted to meet the project objectives:

- ***Improving Quality of services by Training and Supportive supervision***

  The project is providing training and supportive supervision to the health worker of the District Health Office (DHO), particularly to Village Health Workers (VHWs), MCHWs, ANM and staffs nurses, to build their capacity in maternal and child health services. The project also provides the training to FCHVs on pneumonia case management and control of diarrhoeal disease for case management at the community level. Teacher sponsors, VDC s leaders, social leaders, and traditional healers are also oriented about the program to create the supportive environment in the community for the program. They are also expected to increase the service seeking behaviors of the people of the community.

- ***Service Availability and Accessibility***

  Selected maternal and child activities have been carried out to increase service availability at the community level. FCHVs are trained to treat pneumonia and manage diarrhea at the ward level as well as trained to facilitate interactive education sessions in their respective wards. MCHWs are trained to provide obstetric care, antenatal, delivery, and postnatal care, family planning counseling, and other services at the VDC level. VHWs are trained to provide Depo-Provera services at VDC level as well. All the health workers based at health facilities received training in integrated management of childhood illness (IMCI) and are providing services.

- ***Human Resource Development***

  The project is focusing on capacity building of existing human resources of the DHO as trainers and service providers in CB-IMCI, obstetric first aid, and family planning (FP). NRCS project staff are supporting community health workers and health volunteers in the health service management in pneumonia, diarrhea, reproductive health.

- ***Community Involvement to Create Supportive Environment and for Sustainability***

  In order to increase ownership and sustainability, the NRCS has been increasing the active participation of VDC members, local leaders, mothers groups, school teachers, traditional healers, FCHVs, and TBAs in CS–15 activities. The project hired local supervisors and facilitators from disadvantaged communities. The project has given more emphasis on building the capacity in facilitation skills and childhood illness management of local women – FCHVs.

- ***Community Awareness and Behavior Change Communication***

  Participatory Learning and Action, Parenting Health Program, and Mothers Groups Program have been launched to increase literacy among women and increase the health seeking behaviors of caregivers and women.

- ***Operations Research***

  Two operations research (OR) activities have been planed under the project. One OR activity examines the feasibility of cost recovery through selling cotrimoxazole through community health workers and volunteers. The other OR activity involves assessing the feasibility and results of providing obstetric first aid through MCHWs.

Key Interventions of the Project

The following four main interventions have been implemented in order to achieve objectives of the project:

1. Pneumonia case Management (PCM)
2. Control of Diarrhea disease (CDD)

3. Maternal and Neonatal Care (MNC)
4. Family Planning (FP)

2. Objectives and Progress

Objectives	Is Progress on Target for Achieving Objective	Comments
ARI/CDD: Community-based Integrated Management of Childhood Illness (IMCI/CB-IMCI) 0.2 to 0.5 episodes of pneumonia treated per child per year. Number of episodes of pneumonia treated per child per year through FCHVs remains stable after CS-XV staff depart	Yes	
PCM available through trained FCHVs in 90 % of wards	Yes	
80% of trained FCHVs have adequate stock of cotrim after CS-XV staff depart the area.	Yes	
80% of trained FCHVs correctly assess, treat, and counsel for pneumonia. 80% of trained FCHVs correctly assess, treat, and counsel for diarrhea	Yes Yes	
80 % of caretakers report following 3 rules of home care	Yes	As per the CB-IMCI follow-up training outcomes, 76% of the caretakers knew 3 rules of home care, indicating an increasing trend.
80% of care takers give proper dose and course of cotrim	Yes	As per the CB-IMCI follow up training outcome, 78% of caretakers gave proper dose and course of cotrim, indicating an increasing trend.
80% of health facilities have ORT corner in place with essential supplies.	No	70% of ORT corners are functioning as per the CB-IMCI training follow-up result. The CS team needs to ensue during supervision visits.

Maternal and Newborn Care (MNC): 70% of trained MCHWs competent in MNC/BEOC.	Yes	
BEOC available through MCHWs trained in RH at 70% of Sub Health Posts. 80% of SHPs have adequate stocks of essential BEOC and FP supplies in areas without CS 15 staff.	Yes Yes	
200% increased in MCHW contacts for ANC/PNC and delivery	Yes	Need focus to increase the caseload.
Documented results of training & supporting MCHWs in RH & BEOC based on new MOH MCHW RH curriculum	Yes	Need to do FGDs and exit interviews. Analyze the raw data as per protocol and disseminate the findings..
<u>Family Planning</u> 80% of VHWs/MCHWs competent in FP counseling and providing DMPA services.	Yes	
Other Activities		
BCC (Behavioral Change & Communication) Increase caretakers knowledge & awareness of selected M/C survival issues: • Signs & care seeking for pneumonia. • 3 rules of home care for diarrhea. • Signs & care seeking for obstetric complication. Increase the knowledge & # of service seekers for contraceptives (DMPA).	Yes Yes	
Other capacity building objectives: 80% of facilities submit logistics management reports correctly and on time, in areas without CS-15 staff. 80% of NRCS SNs / ANMs demonstrate competency in community-based ARI/CDD (CBAC) training of FCHVs. BCC officer and all BCC supervisors demonstrate competency in training NFE and PE facilitators	No Yes Yes	62% of health facilities submitted. To improve this a 3-day training is planned.

3. Factors that have impended progress towards achievement of objectives

The project managed to implement the planned activities in gradual manner even though the situation was not favorable due to the declaration of a state of emergency in Nepal because of the Maoist insurgency. The environment produced some disturbances in implementation of project activities. One area that was most affected is joint supportive supervision from district teams (DHO, NRCS, and SC/US teams) to community level, Ilaka level and, health post and sub-health post levels. The teams have to limit their field visits because of the security situation. Hence the supportive supervision was inadequate, but the teams will continue more frequent joint supervision as planned.

Frequent transfer of trained DHO staff and dropout of trained NRCS project staff slowed progress in achieving the project's outcomes. To address this situation, the NRCS Board initiated field visits to provide support to the field staff and to discuss the management issues and problem solve. The supportive environment from NRCS Board members is helpful in retaining the staff.

There have been difficulties in supplying cotrim. to the FCHVs due to the limited drug schemes (revolving drug funds) at the health facilities. The DHO needs to initiate drug schemes in all health facilitates to facilitate re-supply of cotrim.

Lesson Learned

- The project staff should be well oriented and trained on new programs such as CB- IMCI so that the program could be delivered efficiently and effectively.
- Orientation to the local leaders, traditional healers, social leaders, and teachers has been found to be helpful to create a supportive environment in the community for the program.
- Joint supervision carried out by the DHO and Nepal Red Cross Society or SC/US to the field is a helpful approach to encourage field level staff and improve performance. Hence, joint supervision will be carried out more frequently in the coming year.
- Follow-up after training is effective in updating the level of knowledge and skills of the health workers and to monitor their performance.

4. Changes in the DIP

There are no substantial changes in the Detailed Implementation Plan.

5. Technical Assistance

Technical assistance is required for completion of operations research to document results of training and supporting MCHWs in RH and BEOC based on the new MOH MCHW RH curriculum, counseling training, and final evaluation of the project. Dr. Tariq, Asia Region Health Adviser, will provide training to the CS team on counseling.

6. Actions Taken in Response to MTE Recommendations

#	Action plan made by the MTE of CS-15		Actions taken to address the MTE recommendations
	Recommendations	**Proposed Action to be taken**	
1.	FCHVs role should be highlighted in the community through NFE, IPC, PE and Mother's group and through street dramas. In addition, the health staff should 'actively' refer clients (after prescribing) back to FCHVs both for follow-up and promotion of home care. This will further support their role in PCM.	Role of FCHVs will be highlighted as per recommendation.	FCHVs roles have been highlighted in the community through PLA, mothers groups program, and parenting education and through street dramas. In addition, the health staff are encouraged to send the clients (after prescribing) back to FCHVs both for follow-up and promotion of home care. FCHVs are reiterated during the follow up visit education on home care for sick children.
2.	It is important that CS-15 staff continue to 'work with' the traditional healers. Their orientation on CB-IMCI may be extended (beyond 1 day) to include technical aspects of ARI (counting breath rates or subjectively assessing for fast breathing, looking for chest indrawing and asking for danger signs) and the importance of referring children with fast breathing and chest indrawing to FCHVs on time.	• Refresher training will be organized for those who received the one-day training. • The one-day orientation will be revised to two days. • Traditional healers will be linked to FCHVs during review meetings.	Traditional Healers orientation on CB-IMCI has been conducted for one day for the first time. Next year the 2 days refresher training will be conducted for them to include technical aspects of ARI (counting breath rates or subjectively assessing for fast breathing, looking for chest indrawing and asking for danger signs) and the importance of referring children with fast breathing and chest indrawing to FCHVs on time. The numbers of participants has been increased to 9 per VDCs from 5 per VDCs.
3.	Quality: Regular feedback should be provided to FCHVs once their data is analyzed and issues such as the importance of caregivers counseling and follow-up discussed.	Quarterly review workshops will be continued.	The follow up CB-IMCI review workshops for FCHV/VHW/MCHW conducted monthly for first 3 months, followed by bimonthly for 6 months, then quarterly basis, in which their knowledge and skill are reviewed to reinforce and provide feedback for improving their performance. The review process focused on counseling of caregivers and follow up on 3rd day of treatment.

4.	We need to find ways to increase the coverage of antenatal care, safe delivery and postnatal care. One of the ways, as discussed between team members and ilaka staff was to map the clients, TBAs and FCHVs, identify areas where pregnant women have not been enrolled and make a plan (with help of BC participants, TBAs and FCHVs) to motivate the communities and family members. It was suggested that this might be tried for a couple of months in one or two Tamang areas and if useful, replicated to all areas. And they need to be provided supportive supervision.	Reinforce the promotion of MCHWs' work through PLA, PE, IPC, VDC meetings, and mothers' group meetings. Supportive supervision will be continued.	In ordered to increase the coverage of antenatal care, clean delivery and postnatal care, the ilaka teams will map the clients, TBAs and FCHVs, with the help of BCC group participants and volunteers to motivate the communities and family members for increasing their care seeking behaviors. PLA facilitators have made social maps in most of the PLA centers. NRCS Ilaka teams are providing continued monthly supportive supervision to MCHWs. In addition to this, the district PHN and NRCS, SC/US district teams also made supervision visits for most of the MCHWs. The ilaka and district NRCS and DHO team expects to increase the close supervision for them.
5.	Limited practice of birth preparedness.	Focus on birth preparedness using birth preparedness package prepared by CEDPA.	The birth preparedness messages have been incorporated in CS-XV key message booklets by replicating the package developed by MOH/CEDPA. The full birth preparedness package is going to be implemented next year.
6.	Shortage of equipment such as torches and BP apparatus should be immediately addressed. Similarly, additional training on antenatal care should be provided as soon as possible.	Will work with DHO and continue to ensure the availability of the supplies and equipment.	The DHO is encouraged for ensuring the availability of the supplies and equipment. The NRCS has made one assessment on this to find out the actual lack of supplies and to focus on refilling the equipment and supplies. The 6-day refresher training has been planned for MCHWs next year, which will focus on antenatal care.
7.	CB-IMCI follow up after training is needed for health facility staff and refresher training is needed for VHW/MCHW and FCHVs to ensure the proper recording and reporting system from the FCHV level to the district level	It will be planned during annual planning session and carried out.	IMCI follow up after training has been conducted for 25 health workers from 21 health facilities in this year. For the rest of the health workers, two days follow up review workshop was conducted in which 23 health workers participated. Another follow-up after training for HF/HW is planned for next year. Refresher training has been planned for VHWs/MCHWs and FCHVs for next year .

8.	During the quarterly review meetings, health facilities, and NRCS staff with support from SC should include practical training for FCHVs on how to use the ARI timer. This should also include caregivers counseling skills, especially focusing on how to identify problems caregivers face during home care and how to counsel them to address those problems.	It will be done during quarterly review meeting/ workshops with FCHVs on recognizing danger signs and using the timer.	Health workers of health facilities, and NRCS staff focused on the practical training for FCHVs on how to use the ARI timer and count respiratory rate, and caregivers counseling skills during the review workshop and at the time of home visits. The duration of the workshop was extended for two days from one day to provide intensive skills to FCHVs on above matters including proper recording and reporting. The FCHVs are also trained as facilitators to conduct the interactive sessions.
9.	Continue carrying out formal MCHW assessments on a quarterly basis, but include a checklist for observation that can be used more frequently i.e. during monitoring/supervisory visits. Continue assessments of delivery/BEOC activities through on the spot observations. Refresher courses should include more emphasis on newborn care during the next half of the project.	Will be continued.	Continued the MCHW assessments on a quarterly basis by using the standard MOH checklist for observation during the monitoring and supervisory visits. Also continued monitoring of the MCHW performance on ANC, delivery/BEOC and postnatal services through on the spot observations and using standard format. It is planned to focus on newborn care during the refresher training and subsequent visits. Replicating the birth preparedness package (BPP) will also address this issue of newborn care as well.
10.	The NRCS ilaka team should be placed at SHP level where intensive and close supervision is possible for at least 7 MCHWs.	Will be placed at SHP in phase two areas.	The NRCS ilaka teams have been placed at SHP level and intensive close supervision is being done by the NRCS SN/ANM to MCHWs. In general the caseload of MCHW on ANC/Delivery/BEOC and PNC services has increased. However the placement of the staff at SHP has made some difficulty for coordinating with HPs In-charge and collection of reports. It is necessary to increase the visits to the HPs for the same purpose.
11.	Monthly recording and reporting formats should be developed and used by MCHWs to capture all information regarding ANC, PNC, and deliveries, including BEOC services, in order to monitor caseload.	Will be developed and used	One standard monthly recording and reporting format has been developed to capture all information regarding ANC, PNC, and deliveries, including BEOC services, in order to monitor caseload. It also gives information about the numbers of ANC visits by each antenatal mother.

12.	Ensure that health facility staff and FCHVs understand the difference between health education and counseling. Conduct counseling training for health facility staff and FCHVs that focuses on problem identification and solutions. Effective counseling increases knowledge of caretakers on danger signs and home care.	Counseling training will be organized.	Although the district level training planned for this year, it is postponed to the first month of next year because of conflict of schedule of Dr. Tariq who is the key trainer and also due the poor security situation in the county. The same training for the health facility staff and CHWs has been planned for the next year and will be implemented after the package has been received.
13.	Review and refine the module for Newborn Care. Incorporate messages for NBC (immediate and within the first 7 days after birth). Train (or give refresher) all MCHWs, VHWs, HPIs, and NRCS staff, using the refined NBC training materials/text.	The module will be refined.	The MCHW refresher training has been planned for next year in which NBC messages incorporated. BPP will also be the effective and helpful material for this.
14.	NRCS and SHP staff need to revitalize the mothers' group meetings and facilitate them on a regular basis. IPC session should be integrated within mothers' group meetings and FCHVs trained on how to facilitate meetings. Their training should also emphasize building their skills for conducting informal and interactive meetings (how to do role-plays, demonstrations, presentations, skits, direct observation, use of IEC materials, etc). MOH SHP staff need to be involved in mothers' group meetings on regular basis. For example, MCHWs and VHWs need to learn more on how to observe mothers' groups and provide feedback to FCHVs. For this, the NRCS and DHO need to establish supervisory checklists and train SHP staff on how to them. Where necessary, the VDCs' role in activating mothers' groups should be explored and strengthened	FCHVS will be selected and trained as facilitators to carry out the sessions.	The mothers group health program replaced the IPC program and has been implemented through trained FCHVs. The FCHVs were trained on how to facilitate meeting sessions. Their training emphasized building their skills for conducting informal and interactive meeting sessions and use of IEC materials. SHP staff were involved in mothers' group TOT and meetings. MCHWs and VHWs learned more on how to conduct the health education sessions and observe mothers' groups and provided feedback to the FCHVs. The session plans and health education package for both FCHVs and VHWs/MCHWs are prepared. The VDCs' roles have been explored and strengthened in activating mothers' groups and VHWs/MCHWs. However some of the MCHWs/VHWs are inactive in health education in comparison to the FCHVs because they are away from their posts for most of the time, as some of them do not have their residence in the VDCs to which they have been posted. The DHO team needs to do supervision and provide feedback to them.

15.	The NRCS BC team should review the training contents of the supervision system and establish different supervisory checklists for NFE/PLA, and IPC sessions separately. The NRCS BCC Supervisors should be made responsible to involve all Motivators and Facilitators in action planning sessions, hold regular facilitator's meetings, and provide technical assistance where necessary. One area where Facilitators would benefit from training is BCC management/facilitation skills.	It will be carried out as per the recommendation made by the MTE team.	The NRCS BCC Officer reviewed the training contents of the supervision system and established the checklists and lesson plans for mothers group health program, PLA, and PE sessions separately. The NRCS BCC Supervisors involved all Motivators and Facilitators in action planning sessions and hold regular facilitator's meetings and provide technical assistance as per need. They hold the regular meeting with Mother Group Health Program facilitators on monthly basis & collect reports & provide necessary feedback.
16	Train PLA Facilitators from the Tamang ethnic group and initiate IPC sessions for them on a large scale. Organize NFE/PLA groups in some pilot areas.	If possible, Facilitators will be selected and trained from the Tamang ethnic group.	PLA Facilitators were selected from the Tamang ethnic group. This year most of the facilitators are Tamang. The mothers group health program (MGHP) was initiated to cover mothers on a large scale and to focus on Tamang communities in each ward, and close monitoring is being continued.
17	Carry out community consultation and organize a timetable for carrying out BCC/IPC sessions. For example, the IPC program could be more effective from Marga to Falgun (December to March).	Carry out as per recommendation made by the MTE	Considering the public business in their farming and other occasions, PE sessions were planned and carried out, particularly during the period from December to March. However, the MGHP is running all year except during the months June-July in some centers because these months are during the rice planting season.
18	Design BC orientation sessions for the political leaders and teachers in order to gain their appreciation and support.	The orientation package will be developed and orientation for the leaders will be organized.	The CS orientation sessions (which includes BCC also) were conducted in district level, Ilaka level and at VDC level involving all political bodies and teachers using an orientation package. The quarterly review workshop has been planned for such political leaders to discuss CS-XV.

19	The second group of MCHWs was trained in December 2000, eight months before the MTE, and they still need supportive supervision from NRCS staff to build their competency. So it is recommended to post three teams, one NRCS ANM staff with one AMN OJT (on the job trainee) in each team, in three areas to provide supportive supervision and assess the performance of the trained MCHWs. At the same time they can be utilized to supervise the performance of the FCHVs who are trained to diagnose, treat, and follow up children with pneumonia and diarrhea because these FCHVs also need to be supervised.	The three teams will be placed in three areas to support MCHWs.	Three teams of NRCS, (one ANM staff with one AMN OJT (on the job trainee) two in each team, were posted in three location to provide supportive supervision and assess the performance of the trained MCHWs. They are also responsible for supervising and assessing the performance of the FCHVs who are trained on PCM and CDD under CB-IMCI package as they also need frequent supervision and follow up for updating their knowledge and skills on management of pneumonia and diarrhea and counseling the mothers/care givers effectively.
20	To strengthen the financial system, it is suggested that the NRCS hire a higher-level finance person.	Higher-level finance person will be hired by NRCS.	One Admin cum finance officer who is a graduate in Business Science has been recruited from November 1, 2001. Because of this arrangement the quality of project work has been improving.

Outcomes of 3rd Annual Program Review Meeting Workshop

The third annual program review workshop was held on September 17-18, 2002 at NRCS Office. A total of 33 participants attended the workshop. Out of these, nine participants were from DHO, 19 from NRCS and five from SC/US. The team critically reviewed the program progress. DHO and NRCS staff jointly presented the presentation on program progress. Based on the program review, the team identified areas for improvement and prepared an action plan for that. The group also prepared the phase-over plan. The action plan and phase over plan prepared by the group is given below.

Plan of action for the forthcoming days prepared during annual program review meeting on 17-18, September 2002.

Recommendation	Action to be taken	By time	Responsible person	Help	Activities
Increase supportive supervision from district team.	Prepare a plan of action for the supervision & follow up the previous action plan.	Oct 2002	Health Post Incharge (HPI), Health Coordinator (HC), Monitoring & Documentation Officer (MDO)	DHO, Public Health Officer (PHO), Team Leader (TL), NRCS President.	Submit the report to NRCS and DHO, analyze it at the time of quarterly review meetings.
Increase supervision from Ilaka to SHPs.	Conduct the supervision as per plan	Oct 2002	Ilaka Coordinator (IC), HPI, Primary Health Care Center Incharge (PHCCI)	PHN, TL, DHO, PHO	Prepare the report and share with ilaka and district
Improve coordination between NRCS and DHO ilaka teams.	Conduct the coordination meeting at Ilaka	Quarterly	IC, HPI, SHPI, PHCCI	HC, PHI, Public Health Nurse (PHN), RHO, Behavior Change Communicatio n Officer (BCCO)	Provide the information earlier to NRCS district staff and DHO district supervisors so that they will be able participate the meetings.
Proper implementation of ORT corners	Ensure the ORT corners are running well in all HFs.	Immediately	,,	,,	The NRCS staff will work together with HF staff and inform about the condition of the corners frequently

Promote the prompt reporting from the Ilaka to the district.	Reporting from SHP to HP by 5th of next month and from HP and PHCC by 8th of the next month.	by next month	,,	,,	Prepare plan and carryout the recording reporting on time.
Ensue that the necessary drugs are available with FCHVs and VHW/MCHW.	SHP, HP and PHCC should ensure that the Cotrimoxazole is available with FCHVs.	by next month	,,	,,	Monitor the cotrim stock with the FCHV on monthly basis.
Participation of DHO staffs in BCC program also.	Share with health education technician of DHO.	as per need	BCCO	DHO, PHO, NRCS President, TL	Conduct an orientation to the DHO supervisors on BCC.
IMCI supervisory training to DHO district supervisors.	Conduct a 5 days long supervisors training as per protocol.	Within 2 months	IMCI focal person, TL, HC, MDO,	DHO, PHO, DPM, NRCS president	Obtain package of the training from Child Health Division, MoH and provide training.
Health program management training.	Manage the training to health program focal persons of the DHO and NRCS.	Within 2 months	DPM, president and Team leader	DPM, DHO President	Explore the suitable package for the training
Provide the feedback on reproductive health (RH) program to the ilaka staff.	Once the analysis of the performance on RH program is completed provide the feedback to the Ilaka coordinators and Ilaka health post in charges.	Quarterly and as per need	RHO, PHN	DHO, PHO, TL, MDO	Carry out review and maintain the feedback mechanism effectively.

7. Phase-Over Plan

Program	Activities	Process and responsible persons
CB-IMCI	❖ Carry out and continue a two day VDC level CB-IMCI review workshop and one day ilaka level review workshop according to the IMCI protocol. ❖ One staff of DHO and one of NRCS or Save the Children US will participate in these two day VDC level CB-IMCI and Ilaka level review workshops and provide feedback to Ilaka/VDC level staff. ❖ The records and reports of these review workshops should be submitted to NRCS and DHO on time for necessary information and feedback.	Ilaka teams of both NRCS and DHO will conduct the workshop for two more times jointly at initial period of next year then DHO Ilaka team will provide it independently.
MNC	❖ Maternal and neonatal and family planning services carried out continuously by the MCHWs will be supervised by DHO/PHN on quarterly basis. ❖ Depo-Provera services provided by the VHWs will be supervised by DHO/PHN on quarterly basis. ❖ Feedback will be provided to them during the time of VDC and ilaka level workshops and ensure the MCHWs are competent in their work.	DHO/PHN and RHO will prepare the plan and carry out. The NRCS RH will transfer the responsibility to Public Health Nurse (PHN) of DHO from next six months.
Mothers group meetings.	❖ Encourage VHWs and MCHWs to supervise mothers groups on monthly basis. ❖ The VHWs will provide reports to DHO and NRCS on monthly basis. ❖ DHO district team will provide feedback according to their performance.	SHPI/HPI/PHCCI will encourage VHWs and MCHWs to follow up mothers groups meetings and submit the reports from VHWs/MCHWs on mothers group meetings.

8. Capacity Building

Objectives	*Planned activities*	*Progress towards Accomplishments*
80% of facilities submit logistics management reports correctly and on time in areas without CS-XV staff.	Assess the reports on yearly basis.	According to the last year LMIS reports submitted to the DHO by the HPs and PHCs of CS-XV phase 1 area, it is found that total 6 (85%), out of 7 health facilities (HP/PHC) had submitted the reports correctly and on time. However, on an average, only 62% of the Health facilities (including the SHPs) have submitted the repots correctly and on time. They are supposed to submit the complete report on quarterly basis with in 1st week of the next quarter as per the LMIS (logistic management information system) procedure. The 3 day LMIS training to DHO and HP/SHP storekeepers has been planned for the next year for both phases to improve the LMIS as per DIP.
80% of the NRCS SN/ANMs demonstrate competency in CBAC training of FCHVs.	Provide CB-IMCI training to NRCS staff. Mobilize the NRCS staff nurse and ANM in planning, conducting training and follow up of the FCHVs training on CB-IMCI.	The staff received the 11 day district level IMCI TOT prior to conducting the FCHV level according to the plans of the CB-IMCI program. Conducted community level CB-IMCI training for FCHVs and followed up by NRCS SN/ANM with the help of HPI/SHPI. According to the close supervision made by SC staff (MDO & HO) during the FCHV training conducted by them, around 90% of the staff are found to be competent in FCHVs training on CB-IMCI. They had followed the CB-IMCI-FCHV training protocol systematically. They were provided with comments and suggestions on the spots as per need.
BCC officer and all BCC supervisors demonstrate competency in NFE & PE facilitators training.	Mobilize the NRCS BCC officer and supervisors in planning and conducting the NFE & PE facilitator training.	According to the close supervision made by SC staff (ED/CDO) during the NFE/PE facilitators training conducted by the BCCO/BCC supervisors, almost all (above 90%) of the staff were found to be competent in the training on BCC. They followed the training curriculum, lesson plans and methods systematically according to the TOT BCC training package. They were provided with comments and suggestions on the spot as per need.

Recent Office of Health Activities Related to Issues Prioritized in the February/March 2002 Institutional Strengths Assessment of SC's Home Office Backstopping of CS Grants

1. Field training/clarification regarding budget line-item flexibility; and training and providing on- or off-the-books activity costing for program managers: These activities were recently conducted by SC Finance and Grants Management staff in Ethiopia for SC's Ethiopia Field Office staff, and are planned for November 2002 and May 2003 for SC Middle-East/Eurasia and Africa area staff.

2. Further develop BCC support capacity by adding a Behavior Change Communication Specialist: Karin Lapping has been hired by SC's Office of Health (OH) in the position of "Positive Deviance and Behavior Change Coordinator" on a part-time basis.

3. Diversify donor base & increase resource mobilization: OH is seeking funding from sources other than USAID/GH/HIDN (which now houses the PVO Child Survival and Health Grants Program) to support OH MCH-related initiatives for immunization; community case management of childhood malaria, pneumonia, and diarrhea; and safe motherhood.

4. Train field staff in & implement capacity assessments at field level: This is now being done with regard to SC's three CS-18 grants in Guinea, Tajikistan, and Viet Nam.

5. Further development and implementation of a Quality Assurance program: This is on the agenda of SC's agency-wide Planning, Monitoring, and Evaluation Working Group.

6. A more systematic approach to building field capacity in management, leadership, and technical and crosscutting (M&E, research, training, etc.) skills and knowledge: OH conducted a week-long training workshop in program planning, monitoring, and evaluation in Bangkok in July 2002 for Asia-area senior SC health program managers. A similar workshop is planned for the near future for Africa-area staff.

ANNEX 1.

BRIEF REPORT OF CB-IMCI FOLLOW-UP AFTER TRAINING

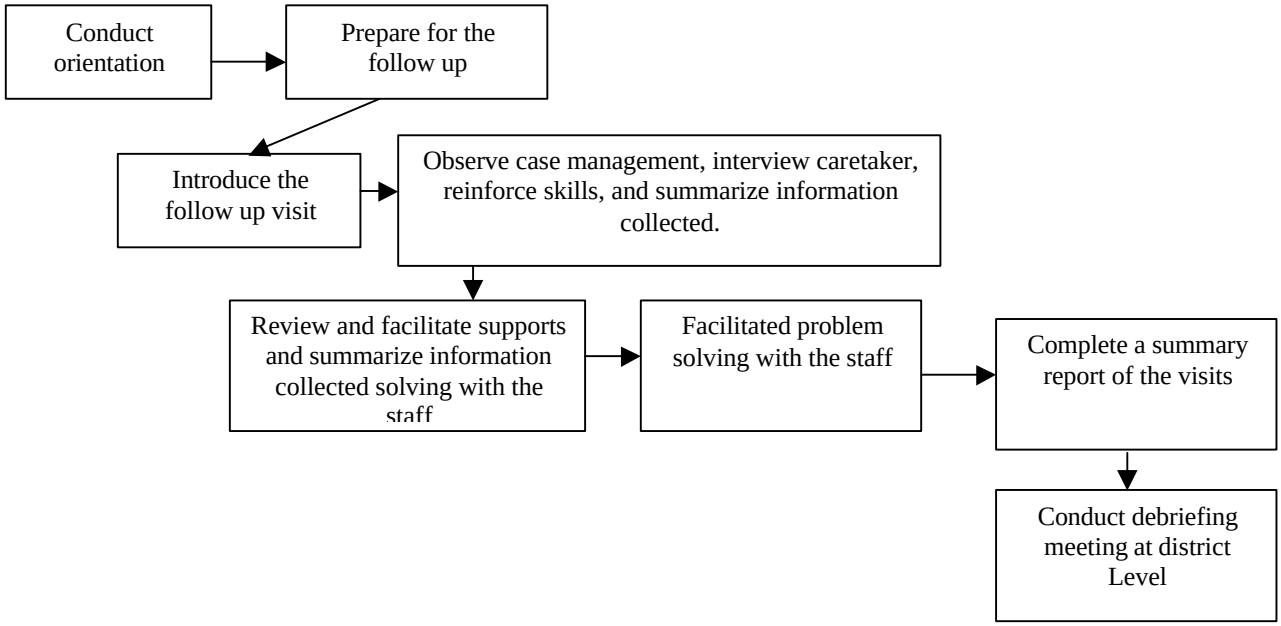
INTRODUCTION

On July 7-16, 2002, CB-IMCI follow up after training was conducted by NRCS Nuwakot in co-ordination with Save the children (SC/US) and CHD/WHO Nepal. A two days long orientation was conducted at SC/US office in Kathmandu and followed by 8 days long follow up which was conducted at respective 20 health facilities. The training program was facilitated by Dr. Sun Lal Thapa, Mr. Sunil Sing and Dr. Tikendra karki from CHD/WHO and Netra Prasad Bhatta as a co-trainer from SC/US.

OBJECTIVE OF THE PROGRAM

1. Reinforce IMCI skills and help health workers transfer these skills to clinical work in facilities.
2. Identify problems faced by health workers in managing cases and help solve these problems
3. Gather information on the performance of health workers and the conditions that influence performance, in order to improve the implementation of IMCI program.

THE MAIN STEPS OR ACTIVITIES FOR THE FOLLOW UP PROGRAM



1. According to the standard series and steps of follow up after training, we conducted a follow up after training in Nuwakot district. For the same purpose, we have conducted two days

orientation program first at SC/US office Kathmandu. Master supervisors' were prepared on the techniques and process of follow up.

2. After conducting the orientation meeting, we all supervisors were divided into 4 groups and moved to assigned areas of the district. Each group was assigned 3-5 health facilities considering the remoteness of the locations. We all supervisors went to the area and perform the follow up activities as per the rules of the follow up program.

3. The team was composed of CB-IMCI focal person and most senior Health Post Incharges (HPI) from DHO-Nuwakot and Nepal Red Cross Society (NRCS) IMCI trained health staff including SC/US IMCI key person. All together 11 persons involved in the follow up after training program in Nuwakot district.

4. Then each group summarized the collected data in the field and it was compiled at district and prepared for the debriefing in the district.

5. Conducted a debriefing meeting in NRCS district office in the presence of health workers of respective health facilities and all supervisors including consultants. A total of 30 participants participated in the meeting.

GENERAL IMMERSIONS

1. The follow up visit is the second but crucial part after CB-IMCI training.

2. As per procedure, the follow up visits should occur within four weeks after training in order to help health workers get started the activities at health facility as per IMCI rules. But because of miscellaneous reasons, it was conducted late.

3. We all realized that the follow up after training is very crucial to update the health workers performance on IMCI. The remaining health facilities and health workers to be followed up as early as possible.

4. District level review workshop to be conducted among them focusing the improvement their IMCI skills and performance on quarterly basis if possible.

GENERAL RESULTS / FINDINGS AND RECOMENDATIONS

RESULT OF FOLOW-UP AFTER IMCI-TRAINING,

- Nepal Red cross society (NRCS) Nuwakot conducted IMCI district TOT for AHW/ANM/SN/HA from district hospital, PHC, HP, and SHP for 11 days in collaboration with Save the children US and DHO Nuwakot in November-December, 2000 and in December 2001-January 2002. Community level IMCI training was also completed.

- A of total 90 Health Workers (HWs) were trained including NRCS staff nurses, ANM, and district hospital clinical staff.

- Total 73 HWs were trained from the SHP/HP/district hospital. Nevertheless, around 8 IMCI trained health workers are transferred to other districts and replaced by untrained ones and in few HF the positions are still vacant.

- At present, there are only 65 IMCI trained health workers in Nuwakot district.

- Out of 65 trained HWs, altogether 25 Health workers were followed up.

- Total No of HF visited (PHC, HP, SHP) - 21

- Total No of HWs followed up - 25

- Total No of children observed - 25

- Total No of caretakers interviewed -25

PROBLEMS WITH HEALTH FACILITY SUPPORT

PROBLEMS IDENTIFIED	**First Follow-up findings**	
	Total No. of HF-21	**%**
Space and equipment		
- No functioning weighing scale	3	14.3
- No IMCI OPD register	0	0
- No timing device	0	0
- No IMCI chart booklet	11	52.4
- No mothers cards	20	95.2
- No thermometer	1	4.8
Oral Rehydration Therapy Corner (ORT Corners)		
- No functioning ORT Corners	6	28.5
- Not enough supplies	0	0
- No ORT register available	21	100

Clinic and referral services - All services not available for children - No referral within 1 hour	6 9	28.5 42.8
IMCI-Drugs - Health facilities have all essential IMCI recommended drugs in stock - All IMCI drugs available except IM Choloramphenicol	0 0	0 0
Quality of records - Records not complete	12	57.2
Training - HF with at least 60% of HWs managing children trained.	21	100

QUALITY OF CASE MANAGEMENT IN CASES OBSEVATION

Information on the quality of case Management	*First follow up findings*	
	No. of HWs = 25	%
Children assessed for all danger sings	16 of 25	64
Children assessed for all main symptoms (cough, diarrhea, fever and ear problem)	21 of 25	84
Children assessed for nutritional status	18 of 25	72
Severe cases referred	-	-
Cases whose immunization status was correctly checked and advised	19 of 25	76
Cases of pneumonia who received a full course of antibiotic at the health facility	8 of 9	88.9
Cases of acute ear infection who received a full course of antibiotics at the health facility	1 of 1	100
Cases of dysentery who received a full course of antibiotics at the health facility	-	-
Cases of malaria who received a full course of antibiotics at the facility	0 of 1	0
Cases of diarrhea with some dehydration given ORS at the facility	8 of 15	53.3

Caretakers of children no referred, advised on going home treatment, home care, continue feeding and at least 2 signs of when to return immediately	19 of 25	76
Caretakers of children <2 yrs. Assessed for feeding	4 of 5	80
Cases who needed to be assessed on feeding who were assessed caretakers were counseled on feeding	4 of 5	80
Caretakers of children given an antibiotics or anti-malaria drug who know: how much to give, times per day and number of days	7 of 9	77.8
Caretakers of children with diarrhea given ORS who know: to give ORS, mix ORS and amount of ORS to give	8 of 15	53.3
Caretaker of children who know all 3 rules at home care (Fluid food and when to return immediately)	19 of 25	76
Cases assessed for other problems	3 of 25	12
Average time spent	19.43	

<u>OBSERVATIONS MADE ON HEALTH WORKERS SKILL/KNOWLEDGE IN PRACTICING IMCI</u>

1. Only 64% of the Health Worker assessed well for all four Danger signs and 84% of them assessed major child symptoms defined i.e. cough, diarrhea, fever and ear problem.

2. 72 % assessed nutritional status.

3. 76 % of the HWs checked Immunization status and advised caretaker to immunize immediately at scheduled immunization clinic nearby.

4. 88 % cases of pneumonia were treated correctly.

5. 53 % cases of diarrhea with some dehydration were given ORS.

6. 53% of caretakers knew to give ORS correctly.

7. Only 76% of caretakers were advised on home treatment, home care, continue feeding and for when to return immediately.

8. Only 12% could assess other problems.

9. Average time taken for case management was 19.43 minutes.

- The follow-up results show that most of the health facilities were not regularly practicing IMCI in OPD. It may be due to the lack of supervision, reinforcement and responses/feedback particularly from the DHO and IMCI focal person from district health office.

ISSUES AND RECOMMENDATIONS ON HEALTH WORKERS SKILLS

1. 36% of Health workers did not assess for danger signs during assessment process indicating a serious problem. So they need to continue regular practice under the supervision of IMCI trained supervisors and focal person.

2. 24% of HWs didn't checked immunization status that means they are pushing many children toward a preventable disease. Therefore, there should be a frequent and regular supervision form different level.

3. Using mother's cards is a must not to miss essential advice that must be given to the caretakers. Mother's card should be supplied regularly basis.

4. Practicing to fill the record forms makes the HW more confidant of his/her skill and will be updated daily basis, therefore laminated record forms should be supplied in health facility.

5. Reinforcement of HWs' skill on every follow-up visit from the district level supervisors' boosts up their enthusiasm and develops honesty to do the job well.

6. HWs should give full time at OPD and she/he should co-ordinate with his assistants in busy hours of the clinic as applicable.

7. HWs should practice IMCI regularly in OPD and they should be serious towards IMCI activities as their own job responsibility.

OBSERVATIONS MADE ON HEALTH SYSTEMS' SUPPORT TO IMPLEMENT IMCI

1. 14% of the health facilities were having no functioning scale.

2. Mother cards were not seen in most of the facilities.

3. There was no thermometer in 5% of the health facilities.

4. ORT corner is not functioning in 30% of the facilities and the register is not maintained in 100% of the health facilities.

5. 100% of the health facilities had supplies like cups/spoon/ORS.

6. Out of 21 Health Facilities, 9 health facilities take more than one hour to reach respective referral sites.

7. In all the health facilities all IMCI drugs are not available.

8. After community level training, children under 5 years cases are decreasing which is matter of pride but there is a need to frequent supervision and supplied adequately.

9. Although the all Health Facilities are supplied with IMCI OPD register and timer, but most of the health workers are not well implementing the IMCI activities and are not completing the recording/reporting. It needs to be improved.

ISSUES AND RECOMMENDATIONS ON SUPPOT OF HEALTH SYSTEM FOR IMCI

1. Mother's cards and laminated recording forms should be supplied immediately and health workers are requested to use them regularly as required.

2. Weighing scales should be repaired or make available which is very important to know the nutritional status of the children.

3. Although diarrheal case incidence is decreasing but still ORT corner concept should be updated and make it functioning well in all health facilities as needed.

4. IMCI drugs supply should be given adequate attention, it is better to strengthen the CDP in HFs and the DHO should ensure for the adequate supply.

5. More attention should be given for proper use of ORT corners and it's continued function in every health facility.

6. Frequent transfer of HWs had created serious problem therefore transfer should be limited only within the IMCI district (Nuwakot, Mahottari, Danusa, Nawalparasi, Bardiya, Kanchanpur, Kaski and Rupandehi)

7. So many cases were treated at community level so cotrim and ORS should be supplied from PHC/HP/VHW/MCHW to FCHV level regularly and adequately.

8. Negligence of health worker in IMCI should be avoided and good performer of IMCI should be appreciated.

9. Nuwakot is IMCI district so the attention needs to be given for IMCI activities as well including the functioning of the reporting system. The IMCI reporting system from the community level to the district health office (DHO) need to be part of HMIS. The DHO needs to report IMCI activity achievements to Child health division, MOH on regular (monthly) basis.

HEALTH FACILITIES AND TEAMS INVOLVED IN THIS FOLLOW-UP AFTER TRAINING

SN	Name of HF	Type of HF	Follow up conducted by	Remarks
1.	Nuwakot	HP	R S. Pyakurel, D. Khatiwada and Y.R. Jha	
2.	Hallekalika	SHP	"	
3.	Bageshwori	SHP	"	
4.	Ganeshthan	SHP	"	
5.	Khanigaon	SHP	"	
6.	Gerkhu	SHP	"	
7.	Chaughada	SHP	"	
8.	Kakani	PHC	Hari Har Sharma, Uma Kusmeli and K Pandey	
9.	Okharpauwa	SHP	"	
10.	Chauthe	SHP	"	
11.	Kumari	SHP	"	
12.	Chaturale	HP	"	
13.	Suryamati	SHP	"	
14.	Ratmate	SHP	Netra Bhatta, Dan Maya Thapa and Santa Dangol	
15.	Duipipal	SHP	"	Extra
16.	Khadgabhanjyang	HP	"	
17.	Deurali	PHC	Rajani Khanal and Ram Mani Ghimire	
18.	Kalyanpur	SHP	"	
19.	Samari	HP	"	
20.	Charghare	SHP	"	
21.	Hospital	D. Hospital	"	Trishuli

Prepared by Netra Prasad Bhatta SC/US, NKT

Annex 2.
Brief Report on IMCI Program Activities in Nuwakot

Introduction

Save the Children U.S. has been implementing Child Survival - XV project through its partner NGO Nepal Red Cross Society, Nuwakot District Chapter and District Health Office, Nuwakot. Presently, the Child Survival - XV project is launching throughout 61 VDCs of Nuwakot district. The project has its main 4 interventions i.e. Pneumonia case management (PCM), control of diarrhea disease (CDD), Maternal and newborn care (MNC) and Family planning (F/P). Out of these 4 interventions of CS-XV project, PCM and CDD have been covered by community based Integrated management of childhood illness (CB-IMCI) and MNC and F/P have been covered by Reproductive health (RH) program. The main goal of this project is to sustained reduction of under five and maternal mortality in Nuwakot district.

Save the Children U.S. has been implementing the community based Integrated management of childhood illness (CB-IMCI) program in Nuwakot district incorporating with Child Survival - XV project. The program is launching in collaboration with DHO and Nepal Red Cross Society in Nuwakot since January 2001 as a part of national health program. The main goal of CB-IMCI program is sustained reduction in under five mortality in Nuwakot district.

Objectives of the CB-IMCI Program in Nuwakot

1. To improve, strengthen and sustain the quality of pneumonia case management and control of Diarrhea disease Program at HF level and in the community level
2. To improve the quality of counseling by Health facilities staff and CHW on home care for Pneumonia and diarrhea diseases.
3. To improve the supply of Cotrim, ORS and other necessary materials for the pneumonia case management and diarrhea disease.
4. To improve the family recognition and prompt care seeking for pneumonia and diarrhea disease and ensure the BCC on service seeking and improved the home care practices.
5. To increase the access to standard case management throughout the district by supporting CHW.
6. To establish the systematic way of treatment of childhood illness and not to leave any underlying disease undetected, which may prove to be fatal.
7. To improve organization of work and simplify the management of childhood illness at the health facility level and community level.
8. To improve monitoring and supervision system of child health program
9. To decrease in under five mortality and morbidity.

Methodology

The training and program was conducted according to the CB-IMCI training package, schedule, checklists, audiovisual aid, forms and formats, books and modules and series developed and provided by the Child health division MoH, Nepal.

The following CB-IMCI activities were carried out in Nuwakot as per the following schedule

Categories of health workers/ activities	Duration (days)	1st Phase program area		2nd phase program area		Total No. of participants trained in Nuwakot
		Date conducted	Number of participants trained	Date conducted	Number of participants trained	
District level Planning workshop	2	Nov. 5-6, 2000	7	Nov. 21, 01	8	DHO/PHO-2 HA-3 Dist. sup.-3 *(total-8)*
DHO district supervisors orientation	1	-	-	Nov. 22, 01	7	District supervisors- 7 (*Total-7)*
AHW/SN/ANM (health workers) training	9+2	November 20-30 and December 3-13, 2000	AHW-29 ANM-3 HA-2 SN-3	Dec.17-27, 01 and Jan. 4-13, 02	AHW-28 ANM-8	AHW- 57 ANM- 11 HA- 2 SN- 3 *(Total- 73)*
VHW/ MCHW training	5+2	May 15-21, May 24-30 and June19-25, 2001	MCHW –25 VHW-29	February 8-14, 15-21 and 22-28, 2002	MCHW –27 VHW-30	MCHW –52 VHW-59 (*Total-111)*
FCHVs training on PCM	5	In between June 20 and July 10, 01	Cotrim seller-280 Referrer- 194	In between Feb. 25 and March 20,02	Cotrim seller-258 Referrer- 275	Cotrim seller- 538 Referrer- 469 *(Total- 1007)*
FCHVs training on CDD	2	In between July 15 and July 27, 2001	459	In between May 15 and June 14, 2002	521	*980*
VDC leaders orientation meeting	1/2	In between June 20 and July 10,	398	In between Feb. 25 and March	365	*773*

Categories of health workers/ activities	**Duration (days)**	**1st Phase program area**		**2nd phase program area**		**Total No. of participants trained in Nuwakot**
		Date conducted	**Number of participants trained**	**Date conducted**	**Number of participants trained**	
		01		20,02		
Mothers group orientation meeting	1	In between June 20 and July 10, 01	5994	In between Feb. 25 and March 20,02	6864	*12858*
Traditional healers orientation	1	In between March 15 and April 10, 2001	155	In between March 10 and 36, 2002	139	*294*
Follow up after training	9	July 7-15, 02	HP-1 SHP-6 (HW- 7)	July 7-15, 02	PHC-2 HP- 3 SHP- 9 (HW- 14)	PHC-2 HP- 4 SHP-15 *(Total HF- 21)* *(Total HW- 25)*

Annex 3.

Annual Skills (Performance Competencies) Assessment Results for MCHWs of Both Phases

Procedure	MCHWs of Early intervention Areas (Oct. 01, to September.'02)				MCHWs of Late intervention Areas (Oct. 01 to September.' 02)			
	# of MCHW's	Total # of cases seen/Observed	Average Score %	Average Score up to Sept.'02 %	# of MCHW's	Total # of cases Observed	Average Score %	Average Score of post test %
FP Counseling	25	221	88	67	18	40	79	89
Condom Counseling	19	92	80	63	4	4	69	87
Pill Counseling	16	125	82	70	14	25	73	88
DMPA Counseling	24	217	84	72	23	69	80	90
DMPA Injection Technique	25	243	84	79	22	82	81	86
LAMP Method	19	102	80	83	10	17	73	86
ANC Examination	25	195	83	73	24	74	80	88
Anemia Management	20	89	81	69	18	45	83	87
Management of suspected Vagina bleeding	3	3	77	56	-	-	-	85
History taking during labor	18	81	85	70	9	12	82	86
Physical examination during labor	18	74	81	65	7	12	79	86

Procedure	MCHWs of Early intervention Areas (Oct. 01, to September.'02)				MCHWs of Late intervention Areas (Oct. 01 to September.' 02)			
	# of MCHW's	Total # of cases seen/Observed	Average Score %	Average Score up to Sept.'02 %	# of MCHW's	Total # of cases Observed	Average Score %	Average Score of post test %
Monitoring during labor	18	78	84	67	6	12	81	87
Management. of Normal labor	17	66	82	64	8	13	82	91
Infection prevention during ANC/PNC	17	62	82	64	5	7	85	86
Immediate post Partum care	14	49	87	75	4	3	82	86
Management of PPH	1	3	92	84	1	1	67	87
Teaching for breast feeding	13	68	85	69	8	16	82	91
Technique of IV Administration	7	27	77	65	5	6	59	90
Resuscitation of new born	1	26	75	40				86
Assessments of sick new born	3	8	76	50	1	3	85	81
Care of Normal new born	6	52	88	62	5	9	78	92
Counseling the mother on new born care	11	52	86	63	7	14	66	90
Catheterization	10	46	84	-	1	4	56	88

Annex 4.

Knowledge Assessment of MCHWs of Both Phases

S R	Name of MCHW	Pretest (in %)	Post test (in %)	Post test after 3 months (in %)	Post test after 9 months (in %)
1.	Shanti Maya Ghale	33.5	99	89.5	96
2.	Prem Kumari Dimdung	43.5	95	91	92
3.	Saraswati Thapa	28.5	95	86	
4	Rita Gurung	32.5	68	86.5	76
5	Anjana Shrestha	33	80	93	
6	Sumitra Paneru	33.5	92.5	73	
7	Durga Kumari Khadka	34	92	89	94
8	Saraswati Bhandari	54	77	70.5	
9	Durga Devi Adhikari	45	76.5	75	
10	Budheshwari Khadka	42	91.5	97	
11	Gita K. Chitrakar	41	84.5	79.5	
12	Ganga Bajagai	46	72	88	
13	Bishanu M. Shrestha	40	72	73	
14	Usha Rijal	47	81	95	
15	Durga Rijal	38	87	93	
16	Pramila Dahal	39	78	76.5	
17	Nema Aryal	47	91	96	
18	Tulshi Batta	45	92	95	
19	Goma Devi Bhatta	45	89	97	
20	Bhagwati Rimal	35	95	-	
21	Ranjana Neupane	35	85.5	97	
22	Narayani Thapa	36	95	81.5	
23	Bir Maya Tamang	36	85	97	
24	Gita Kr. Phuyal	45	91	98	
25	Shanti Maya Tamang	32	86	88	
26	Kamala Pandey	41.5	89	94	
27	Saraswoti Adhikari	46	93	91	
Total		**1074**	**2332.5**	**2290**	**358**
Average		**40**	**86**	**88**	**89**